

Name:

Mailing Address:

CASE NAME :

CASE NUMBER:

DATE MAILED NAME:

WORKER'S NAME:

TELEPHONE NUMBER:

LOCAL AGENCY:  
ADDRESS

Please answer all questions and return this form to your eligibility worker by: \_\_\_\_\_.  
If you have any questions or need help completing the form, please call the worker listed above.

1. Has your address changed? What's changed? ☐ Mailing address ☐ Home address

Give us your new address: \_\_\_\_\_

2. Please give us your current telephone number: \_\_\_\_\_

3. List all children and parents or caretaker relatives who live in the home.

<u>Name</u>	<u>Date of Birth</u>	<u>Place of Birth</u>	<u>For children, list the names of parents living in the home:</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

4. If both parents are in living the home, are they married to each other? ☐ No ☐ Yes

5. List the income (money) received by household members during the past month and attach proof, such as paycheck stubs. Include income from sources such as work, support, disability, retirement, VA benefits, unemployment, etc. Do not include the wages of any child under age 19 who is a student.

<u>Who Receives Income?</u>	<u>Amount</u>	<u>Source</u>	<u>How Often Received (daily, weekly, monthly, etc.)</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

6. If you are working, and have child or adult day care expenses, list who receives care and monthly costs for each:

7. List changes in your health insurance, including the company name, policy number, coverage, date of change, type of change (coverage started, stopped, etc.):

I have given true and correct information on this form to the best of my knowledge and belief. I understand that the information I have provided will be used to document the identity of my child under age 16. I understand that if I give false information, withhold information, or fail to report a change, I may be breaking the law and could be prosecuted. I agree to assign my rights to medical support and third party payments, and the rights of my children for whom I am applying, to the Department of Medical Assistance Services for services paid by Medicaid. I authorize DSS and the Department of Medical Assistance Services (DMAS) to obtain from any source any information needed to review my eligibility.

Signature of Recipient or Authorized Representative

Date

Relationship to Recipient

Telephone Number(s)

**Voter Registration - Check one of the following:**

**If you are not registered to vote where you live now, would like to register to vote today?**

- ☐ Yes, I would like to register to vote. (If you would like help filling out the voter registration application form, we will help you. The decision to accept help is yours. You also have the right to fill out your voter registration application form in private.)
- ☐ I do not want to apply to register to vote today.

**IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.**

Applying to register or declining to register to vote will not affect the amount assistance or services that you will be provided by this agency. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with: Secretary of the Virginia State Board of Elections, Ninth Street Office Building, 200 North Ninth Street, Richmond, VA 23219-3497, (804) 786-6551.

**DO NOT WRITE IN THIS SECTION\*\*\*\*\*AGENCY USE ONLY \*\*\*\*\***

**A. CN ELIGIBILITY EVALUATION VERIFICATION/INFORMATION ELIGIBILITY MET**

**1. NON-FINANCIAL CRITERIA:** \_\_\_\_\_ YES NO

**2. COVERED GROUP:** \_\_\_\_\_ YES NO

**3. FAMILY UNIT/BUDGET UNIT DETERMINATION:**

**4. INCOME: SOURCE AMOUNT DATE REC FREQUENCY VERIFICATION**

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

COUNTABLE INCOME: \_\_\_\_\_ INCOME LIMIT: \_\_\_\_\_

**5. HEALTH INSURANCE CHANGES SINCE LAST ELIGIBILITY DETERMINATION:**

**6. ELIGIBLE INDIVIDUALS and ACs:** \_\_\_\_\_

**NEXT RENEWAL DATE:** \_\_\_\_\_

**7. INELIGIBLE INDIVIDUALS:** \_\_\_\_\_

**REASONS:** \_\_\_\_\_ **MANUAL CITATION:** \_\_\_\_\_

**B. MN (SPENDDOWN) EVALUATION RESOURCE INFORMATION MUST BE OBTAINED AND EVALUATED**

**8. RESOURCE TYPE VALUE VERIFICATION**

_____	_____	_____
_____	_____	_____
_____	_____	_____

COUNTABLE RESOURCES: \_\_\_\_\_ RESOURCE LIMIT: \_\_\_\_\_

**SPENDDOWN BUDGET PERIOD FROM:** \_\_\_\_\_ **TO** \_\_\_\_\_

**WORKER'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**SUPERVISOR'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**Attach all verification/documentation to this form.**